Stable Grounds LLC | Rebecca Cohen, Psy.D. CT 003385

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled Psychotherapy and related services.		
Patient Primary Diagnosis Not Applicable.		Primary Diagnosis Code
Patient Secondary Diagnosis Not Applicable.		Secondary Diagnosis Code

If scheduled, list the date(s) the Primary Service or Item will be provided: Intake Date Scheduled for: [ ] Check this box if this service or item is not yet scheduled
Date of Good Faith Estimate: _____01/15/23_____
Provider Name Estimated Total Cost Rebecca Cohen, PsyD. $9855.00
Type text here
Total Estimated Cost: $ 9,855.000

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are reoccurring, “The estimated costs are valid for 12 months from the date of the Good Faith Estimate.”]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type
Stable Grounds LLC /Rebecca Cohen, PsyD		Psychologist
Street Address 3074 Whitney Ave. Suite 2-2		
City Hamden	State CT	ZIP Code 06518
Contact Person Rebecca Cohen, PsyD.	Phone 203-747-8734	Email rc@stablegroundstherapy.com
National Provider Identifier 1558561761		Taxpayer Identification Number 46-1457649

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Intake Assessment	Telehealth	N/A	90971	1	$300.00
Psyhotherapy	Telehealth	N/A	90837	39	$9,555.00

Total Expected Charges from [Provider/Facility 1] $	9855.00
Additional Health Care Provider/Facility Notes	

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call [HHS PHONE NUMBER].

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call [HHS NUMBER].

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Acknowledgement of Receipt of Good Faith Estimate

I have received and understood the Good Faith Estimate for Healthcare Goods and Services provided by Dr. Rebecca Cohen, PsyD and Stable Grounds LLC.

_____

Client Printed Name

_____

Client Signature and Date

_____

Parent/ Legal Guardian Printed Name

_____

Parent/ Legal Guardian Signature and Date